Authorization For Release Of Medical Information

Patient's Name	Date of Birth	Date of Request	
Patient's Street Address	City	State and Zip	Phone

For the Patient: I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (title 45 CFR, parts 160 and 164), the Federal Rules For Confidentiality Of Alcohol And Drug Abuse Patient Records (title 42 of the CFR, chapter 1, part 2), and/or state laws. I understand my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I understand that my health information may contain information created by other persons or entities including healthcare providers and may also contain drug and alcohol, mental health, HIV/AIDS, psychotherapy, genetic, reproductive and sexually-transmitted disease information. I further understand that by signing this document, I am authorizing the release or exchange of this information with the person or organization named below.

I understand I may revoke this information at any time by notifying Mission of Mercy in writing. However, the revocation will not have any effect on actions Mission of Mercy took before receiving the revocation.

I AUTHORIZE MISSION OF MERCY TO RECEIVE/DISCLOSE MY PROTECTED HEALTH INFORMATION TO THE FOLLOWING PERSON OR ORGANIZATION:

Group Requesting/Releasing Information:
Mission of Mercy
22 S. Market St., STE 6D
Frederick, MD 21701
Phone: 410.340.3791
Fax: 301.500.3064

Group Requesting/Releasing Information:
Name:_____
Address:_____
_____
Phone:_____
Fax:_____

Description of individually identifiable health information to be received or disclosed (check all that apply):

☐ All records ☐ Other (Describe)_____
Dates of the Records to be Disclosed: From:_____ To:_____ **All** ☐

This authorization expires one year from signature date or on: _____/_____/_____(mm/dd/yyyy)

Signature of Patient or Patient's Legal Representative	**Print Name and Relationship to Patient**	**Date Signed**

Verified By:_____ Print Name:_____